







By Lt. Rich Hansen

his story proves that even the most experienced maintainers make mistakes. We now can look back on a case of serious procedural and communication breakdown and take away a lesson learned instead of a few body bags.

The maintenance was straightforward: Baby-sit an aircraft for four weeks during a wire modification, feed it, change its diaper, and send the plane back home to its parents. That was the plan, but it wasn't as simple as we thought. The task required us to remove the floorboards and associated panels so our station test-article preparation (TAP) people could incorporate a wire modification. We removed those floorboards and the forward cabin's kick panel, which covered four wire-bundle brackets and the collective push rod, and sent the aircraft off to TAP for a month.

During the mod period, we had to do minor O-level work on the aircraft. These jobs weren't a big deal: Remove a panel here and remove a bolt there. Our in-process procedures were rock solid, and we crossed our T's and dotted our I's in time to turn this baby over to its rightful owners. We flew a joint functional check flight, and the aircraft was cleared to go back home.

The receiving command called us a few days after the transfer and said we had neglected one tiny detail. During the modification, the original wire-bundle bracket bolts were removed to allow room for the new wire bundle. Those four bolts were wrapped neatly in a parts bag and zip-tied just above the wire harness and the collective push rod. We had done that so no one would forget to re-install them. Oh...the best-laid plans.

We had failed to use those rock-solid, inprocess procedures I told you about: We didn't document the removal of the forward cabin's kick panel. That mistake was bad enough, but the problem was compounded when a mystery mechanic removed the wire-bracket bolts and neatly stowed them in that cavity. Multiple tasks were involved with the maintenance on that aircraft, and we still don't know who removed the bolts, or why paperwork wasn't initiated. We also didn't communicate—an important lesson learned.

When the aircraft finally had completed the modification and was being put back together, the forward cabin's kick panel was handed over to the TAP folks for a fit check. We should have installed that panel ourselves because that step led to the breakdown in communications. The TAP engineer told the mechanic, "No worries, I will take it from here and will let you know when you can come back to install the panel." The eager engineer then fully installed the panel to complete the fit-check but never told the maintenance folks what he had done.

This simple error, when teamed with the lack of paperwork on the panel and bracket bolts, allowed us to miss the need for a final product inspection. If everyone does his job, follows the processes and procedures, documents all work, and communicates, no one ever again will have to write this type of article.

Lt. Hansen is the maintenance officer at HX-21.

## Who Ate the Ritz Bitsp

By AMC(AW) Jack Eckert

faced another typical OEF flight-op night: "LSE, chocks and chains, spot 5." I thought, "Here we go again, another hot pump for the evening." The LSE orchestrated the event: pilots in, pilots out, grapes in, and start refuel. I could taste the routine and was shocked when it suddenly changed.

Out of the blue, the line supervisor rushed up to me. He had heard a loud "Pop" from the rotor head and now heard a very distinct whine. Could this be a blade-fold wiring harness coming apart? The ground crew was concerned because the sound just wasn't normal.

I went into the aircraft and told the pilots about the noise, and they shut down the aircraft, so we could investigate the problem. A quick call over the RAT to flight-deck control put everyone on the same sheet of music. "Stand clear of spot 5, disengaging rotors on Black Knight 614," rang out over the 5MC.

The rotor speed decreased, and maintainers were ready to seek answers and to fix problems. When the rotors stopped, a plastic Ritz Bits bag floated down from the rotor head like a feather.

A thorough check revealed all was well with the rotor head and the helicopter, and it launched shortly afterward with no further incidents.

If not for the quick actions of the supervisor, this incident could have turned into a FODed engine. We take great pains to maintain a FOD-free environment, but it's easy to get caught off guard by unforeseen

events. Did this trash come
up from a sponson or from
someone being careless? We
never did find out, but I
salute our Sailor for his
quick actions.

Chief Eckert is the flight-deck coordinator at HS-4.

